Fermilab Document: WDRS ER: **Recipient Application for Vacation Donation**	Document #: ER-016	Issue date: 10/01/2010	Revision #:	Revision date:

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APPLICANT INFORMATION AND AUTHORIZATION:

APPLICANT'S NAME: (LAST, FIRST, MI)	EMPLOYEE ID#:	DIVISION/SECTION/CENTER-DEPARTMENT:
WORK E-MAIL ADDRESS:	HIRE DATE:	LEAVE OF ABSENCE (LOA) - FIRST DAY OFF WORK:
LOA – FIRST DAY LEAVE WITHOUT PAY (if known):	ANTICIPATED RETURN TO WORK DATE:	PREFERRED METHOD OF CONTACT DURING LOA:

A. Request for Donation:

I hereby request to receive donated vacation time under the Fermilab Vacation Donation Program. I certify the following:

- I am unable (or expect to be unable) to perform my job duties due to a non-occupational medical emergency as defined in the Fermilab Vacation Donation policy.
- I have received (or expect to receive) authorization by a health care provider for this medical emergency.
- I will have exhausted all leave balances. Without a donation, I will be off work at least two weeks without pay.
- I am not currently receiving disability benefits.
- I have read the Fermilab Vacation Donation policy (http://wdrs.fnal.gov/policies/policy/vacationdonation.html).

B. Authorization for Soliciting Donations*: (check one of the two options below)*

__ I authorize my name, department, general nature of medical emergency to be included in the solicitation notice

OR

__ I authorize my name and department to be included in the solicitation notice, but **do not** authorize the release of the general nature of my medical emergency.

C. Solicitation Notices:

I would like the following divisions/sections/departments/buildings/floors/etc. to be included in the solicitation notice: _____

__ I authorize the Fermilab Vacation Donation "on-call" distribution list to receive my solicitation notice.

By submitting this application, you consent to the release of pertinent medical facts to document your serious medical emergency. You may refuse to sign this authorization. However, if you refuse, you will not be permitted to participate in the Vacation Donation Program. You have the right to revoke this authorization, in writing, at any time except to the extent that Fermi National Accelerator Laboratory or its authorized representatives have taken action in reliance on it.

You hereby waive any right of access provided by law (including the Privacy Act of 1974, 5USC 552a) to information or records concerning the persons who donate leave for your use in response to this application. You understand that there are no guarantees as to the number of hours of leave that will be donated, as participation in this program is strictly voluntary. You understand any donated leave received is included in your gross income, considered "wages," and taxed accordingly per Internal Revenue Service, Letter Ruling 9051005.

This authorization shall expire upon the earlier occurrence of: revocation of the authorization by you or completion of the medical emergency. This form will be retained by Fermilab for a period of one year from the date the leave transfer is executed.

_____ _____

APPLICANT'S SIGNATURE* **DATE**

**An immediate family member may complete this form if the employee is incapacitated.*

FOR USE BY HUMAN RESOURCES ONLY:

DATE RECEIVED:	DATE PROCESSED:	REQUEST APPROVED: ☐ YES ☐ NO